**Client Advisory to Consult a Physician**

Fertile Womb Lifestyle is committed to your health and wellbeing. Although we have a great deal to offer, we cannot totally replace the resources available through biomedical physicians. Consequently, we recommend you consult a physician regarding any condition or conditions for which you are seeking a natural remedy. For this reason, we request you read and sign the following statement.

We, the undersigned, do affirm \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has been advised by a F.L.O.W. Coach at Fertile Womb Lifestyle to consult a physician regarding the conditions for which such client seeks natural remedies.

Client Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Coach’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

# Client Privacy Agreement

I understand all verbal or written information I share with the Fertile Womb Lifestyle F.L.O.W Coach will be kept private and confidential.

# Informed Consent to Natural Remedy Recommendation

The natural remedies recommended are from plant, animal, and mineral sources and are traditionally considered safe, although some may be toxic in large doses. I understand some natural remedies may be inappropriate during pregnancy and breastfeeding. Some possible side effects of taking natural remedies are nausea, gas, stomachache, vomiting, diarrhea, rashes, hives, and tingling of the tongue.

I understand natural remedies need to be consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant taste or smell. I will immediately notify a F.L.O.W. Coach at Fertile Womb Lifestyle of any unanticipated or unpleasant effects associated with the consumption of the herbs.

I will notify a F.L.O.W. Coach at Fertile Womb Lifestyle about my pregnancy or breastfeeding status during the initial consultation and ongoing treatment. I do not expect the Fertile Womb Lifestyle F.L.O.W. Coach to be able to anticipate and explain all possible risks and complications of treatment and I wish to rely on them to exercise judgment based upon the facts known to them, in my best interest. By voluntarily signing below, I show I have read, or have had read to me, this information, I have been told about the risks and benefits, and I have had the opportunity to ask questions. I intend for this consent form to cover every aspect of the health coach’s recommendation about my present and future conditions, for which I seek natural remedies.

To be completed by client (or client’s representative if the client is a minor or is physically or legally incapacitated).

Client’s Name (Print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by Fertile Womb Lifestyle F.L.O.W. Coach providing information and obtaining consent.

Health Coach’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

# PERSONAL INFORMATION

|  |  |
| --- | --- |
| First Name: |  |

|  |  |
| --- | --- |
| Last Name: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Email: |  | How often do you check email? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Phone: Home: |  | Work: |  | Mobile: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Age: |  | Height: |  | Birthdate: |  | Place of Birth: |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Current weight: |  | Weight six months ago: |  | One year ago: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Would you like your weight to be different? |  | If so, what? |  |

# SOCIAL INFORMATION

|  |  |
| --- | --- |
| Relationship status: |  |

|  |  |
| --- | --- |
| Where do you currently live? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Children: |  | Pets: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Occupation: |  | Hours of work per week: |  |

# HEALTH INFORMATION

|  |  |  |
| --- | --- | --- |
| Please list your main health concerns: | |  |
|  |  | |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Other concerns and/or goals? | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Any serious illnesses/hospitalizations/injuries? | |  |
|  |  | |

|  |  |
| --- | --- |
| How is/was the health of your mother? |  |

|  |  |
| --- | --- |
| How is/was the health of your father? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| What is your ancestry? |  | What blood type are you? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| How is your sleep? |  | How many hours? |  | Do you wake up at night? |  |

|  |  |
| --- | --- |
| Why? |  |

|  |  |
| --- | --- |
| Any pain, stiffness, or swelling? |  |

|  |  |
| --- | --- |
| Constipation/Diarrhea/Gas? |  |

|  |  |
| --- | --- |
| Allergies or sensitivities? Please explain: |  |

# WOMEN’S HEALTH

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are your periods regular? |  | How many days is your flow? |  | How frequent? |  |

|  |  |
| --- | --- |
| Painful or symptomatic? Please explain: |  |

|  |  |
| --- | --- |
| Reached or approaching menopause? Please explain: |  |

|  |  |
| --- | --- |
| Birth control history: |  |

|  |  |  |
| --- | --- | --- |
| Do you experience yeast infections or urinary tract infections? Please explain: | |  |
|  |  | |

# MEDICAL INFORMATION

|  |  |  |
| --- | --- | --- |
| Do you take any supplements or medications? Please list: | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| Any healers, helpers, or therapies with which you are involved? Please list: | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| What role do sports and exercise play in your life? | |  |
|  |  | |

# FOOD INFORMATION

|  |
| --- |
| What foods did you eat often as a child? |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| What is your food like these days? |

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Breakfast |  | Lunch |  | Dinner |  | Snacks |  | Liquids |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |

|  |  |
| --- | --- |
| Will family and/or friends be supportive of your desire to make food and/or lifestyle changes? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Do you cook? |  | What percentage of your food is home-cooked? |  |

|  |  |
| --- | --- |
| Where do you get the rest from? |  |

|  |  |  |
| --- | --- | --- |
| Do you crave sugar, coffee, cigarettes, or have any major addictions? | |  |
|  |  | |

|  |  |  |
| --- | --- | --- |
| The most important thing I should do to improve my health is: | |  |
|  |  | |

# ADDITIONAL COMMENTS

|  |  |  |
| --- | --- | --- |
| Anything else you would like to share? | |  |
|  |  | |
|  |  | |
|  |  | |